acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), or AIDS dementia complex developed several years after contracting the infection. All had received one of the following neuroleptics on a regular basis:

thioridazine (Mellaril)	50 mg twice a day
haloperidol (Haldol)	20 mg twice a day
thiothixene (Navane)	20 mg 3 times a day

All of these patients had similar social and psychiatric histories characterized by innumerable promiscuous homosexual and heterosexual contacts in an area of high endemicity (San Francisco), complicated by poor hygiene and living conditions and inadequate nutrition. Such patients are prime candidates for the development of AIDS and related conditions. All of these patients appeared to be in excellent physical condition with normal blood counts. Only two showed relative lymphopenia and an altered ratio of helper and killer T lymphocytes. None of them showed any AIDS-connected pathology. The fact that the disease is late in onset or may not manifest itself at all could possibly be attributed to inhibition of calmodulin due to regular exposure to neuroleptics or to blockade of dopamine receptors on lymphocytic membranes. It should be noted also that inactive phenothiazine metabolites, such as the sulfoxides, which are devoid of central nervous system effects, inhibit intracellular calmodulin functions.

Clearly, further epidemiologic studies are needed to establish whether or not neuroleptics possess a protectant effect on HIV infections. We hope that this preliminary report will stimulate such studies in view of the obvious therapeutic potential in nonpsychotic patients infected with this virus.

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Post-lumbar Puncture Headache

To THE EDITOR: The article by Raymond and Raymond on post-lumbar puncture headache in the May 1988 issue[1] reminded me of my own experience with palliation of this condition. Four years ago at age 44, I developed right-sided neck pain and headache with partial left ninth cranial nerve mononeuritis. The results of the initial blood studies and computed tomographic scan were negative, and after ten days of symptoms a lumbar puncture, which also proved negative, was done with a No. 20 needle. Despite an 18-hour period of post-tap recumbency, I had a new type of headache the next morning. Headache number two was relieved promptly upon assuming recumbency. There then followed a period of ten days during which I learned that I could remain upright only five minutes or less before the headache and nausea got the better of me.

An epidural blood patch was discussed several times with my neurologist, but his uncertainty as to the cause of headache number one led him to advise recumbency and analgesics. At this point I reasoned that because gravity was the enemy, I would try the other terrestrial equivalent of weightlessness besides bed rest—water immersion. In the backyard spa I was able to sit up without symptoms. Whether this was a consequence of a "weightless" state or the hydrostatic equivalent of an abdominal binder, as mentioned in the article, I am not certain.

The original symptoms were clarified when I heard a left carotid bruit after my soak. An angiogram the next morning revealed bilateral internal carotid arterial dissections that healed without residual symptoms. Treatment was aspirin and four weeks of bed rest. By the time I was up and about, the post-lumbar puncture headache had resolved.

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Low Back Pain

To THE EDITOR: I read with interest "Managing Low Back Pain—A Comparison of the Beliefs and Behaviors of Family Physicians and Chiropractors" in the October 1988 issue.[1] Back pain, as the authors describe, is a very common and costly health problem. Research designed to gather information on the diagnosis and treatment of back pain is certainly needed.

The article indicated that there is little known about the relative cost-effectiveness of chiropractic care versus allopathic or osteopathic care. Comprehensive comparisons were made between chiropractors and family physicians. Unfortunately, no statistics were presented that differentiated between allopathic and osteopathic family physicians.

Osteopathic physicians receive training in manipulative therapy as well as drug therapy for back pain. Further analysis of these data and future studies specifically identifying and analyzing osteopathic care could yield important information regarding the effective management of low back pain.

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Ethical Issues in the Treatment of Sexual Dysfunction in HIV-Seropositive Patients

To THE EDITOR: Ethical issues in the treatment and care of patients with the acquired immunodeficiency syndrome (AIDS) are far reaching. In caring for a number of patients in various stages of the disease over the past two years, I have found their plight a precarious one. The clinical presentation of these patients varies widely with clinical setting and population and from patient to patient. It seems the ethical issues in daily clinical care often cannot be generalized, specified, or codified, as can such issues in research or policy settings. Such an ethical dilemma is shown in the following case presentation.

A 55-year-old man was referred to our support group after expressing extreme anxiety associated with the revelation of his positive test results in an infectious disease clinic. The patient presented to our group stating that, in addition to being found to have the human immunodeficiency virus

(HIV), he also suffered from hypertension and diabetes mellitus.

The patient also revealed that he was being treated in a sexual dysfunction clinic for erectile dysfunction secondary to peripheral vascular disease associated with diabetes. Before his diagnosis of HIV seropositivity, the patient had been promised a vacuum-type device, called an "Erectaid," that suctions blood into the penis. Then the penis is banded to prevent blood from escaping, thereby increasing the amount and duration of erection.

That this new diagnosis had presented a dilemma to the sexual dysfunction clinic staff was obvious, as the patient complained to the group that the clinic was "stalling" in giving him the device that had been promised earlier. This patient had frequented bathhouses before his positive test results and was ambivalent regarding his sexual practices in the future. He made no commitment to the sexual dysfunction clinic staff to use his newly functional penis inside a condom.

The ethical issues involved in this case are clear. Do we as physicians have the right to withhold treatment of sexual dysfunction in patients who have a potentially lethal disease that can be transmitted during intercourse? Should this "right" be contingent upon whether or not the patient agrees to practice "safe sex"? By what measure can we be responsible if a patient does infect another person while using a device to enhance sexual function? If we do not treat sexual dysfunction in HIV-seropositive patients, are we infringing upon the rights of the individual, as this patient alleged? And what of society and our responsibility to the health of potential partners? Are a patient's verbal assurances sufficient, or does there need to be a formal psychiatric assessment of a patient's stability and reliability?

As the AIDS epidemic continues, it will present us with conflicts such as the dilemma described that reflect the ambiguities arising when treating HIV-infected patients.

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